RESOURCE AND PATIENT MANAGEMENT SYSTEM

Onsite RPMS-EHR Onsite Setup

Agenda

2012

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

Resource Patient Management System
Electronic Health Record
Clinical Application Coordinator & Implementation Team
Onsite "RPMS EHR Setup"

Background

The RPMS Electronic Health Record (RPMS-EHR) is a new suite of software applications designed to move most clinical transactions from paper-based to an electronic environment. The EHR uses upgrades of existing RPMS applications and clinical data, but provides a graphical user interface (GUI) that facilitates access to and direct entry of this data by clinical users. The two most significant clinical enhancements provided by the EHR are the direct entry of orders (pharmacy, laboratory, radiology, nursing, etc.) by providers, and the on-line documentation of clinical encounter notes. In addition, the EHR will make clinical decision support tools available to providers at the point of care, and will make the medical record immediately accessible to all authorized users.

Implementation of an electronic medical record at any health care organization is a complex and lengthy process, requiring preparation and changes in essentially all areas of a medical facility. Rolling out an electronic record system at any facility will require a considerable training effort at the time of implementation, as well as an ongoing program of training and support.

Purpose

The Clinical Application Coordinator (CAC) and members of the RPMS-EHR implementation team provide ongoing operational support for certain RPMS packages that comprise and/or interface with the Electronic Health Record. This onsite technical consultation will provide CACs, Pharmacy Package Administrators, Laboratory Package Administrators, Clinical Champions, Medical Record Administrators, Data Entry Operators, Business Office Professionals, Site Managers and other Implementation Team members with the opportunity to both setup and configure the Electronic Health Record for use at their facility.

For this reason, the "Onsite EHR Setup" technical consultation incorporates the principles, practices, and techniques of adult education. The site is expected to setup a computer training room for this week. All members of the "Implementation Team" are expected to be available and participate for the entire week. The Implementation Team should include representation from (a) Medical Staff (b) Nursing (c) Pharmacy; (d) Laboratory and Radiology; (e) Medical Records; (f) Information Technology; (g) Coding and Data Entry; and (h) Business Office.

Tentative Schedule, Goals, and Objectives *(Could include Day 4 Session)*

Day One

Time: 8:30 A.M. - 12:00 P.M.
1:00 P.M. - 5:00 P.M.

- Welcome and Introductions
- Goals, Objectives, Expectations
- EHR Business Process "walk-through"
  - The purpose of the "Walk-through" is to assess the business process for taking care of a patient at the facility. The highly configurable Electronic Health Record will be setup to align with the sites clinical and business processes. We highly suggest that the consultants and Implementation Team select a "Demo Patient" and walk-through a patient care scenario that begins with Patient Registration and ends with submitting a claim. All clinical and business processes should be observed on paper.
  - Patient Registration Process (Use of "Face Sheet")
  - Scheduling, PIMS, Appointment Books
  - Nursing Triage (Documentation of (a) Chief Complaint, (b) Vital Signs, (c) Tobacco Screening, (d) Alcohol Screening, (e) Point-of-Care Labs, (f) Domestic Violence Screening, (g) Patient Education, and (i) Immunizations).
  - Medical Visit (Documentation of (a) Repeat Vital Signs; (b) History of Present Illness; (c) Review of Symptom; (d) Past Medical History; (e) Social History to include Alcohol and Tobacco; (f) Domestic Violence Screening; (g) Exams to include Diabetic Foot Exam, Pap Smear, & Breast Exam; (h) Purpose of Visit (e.g. Type 2 Diabetes Uncontrolled with Retinopathy, Nephropathy, & Neuropathy) to include E-Codes; and Evaluation & Management (E&M) Codes.
  - Orders to include Immunizations, Injections, Point-of Care Lab, Reference Lab, Pap Smear, Medications, Radiology, Mammography, Ultrasound, Fluoroscopy, & Dressing Change.
  - Laboratory to include (a) Medical Necessity; (b) Reference Lab (How are Reference Labs Ordered and Entered into RPMS); (c) Laboratory Examinations performed on a date other than the date ordered; (d) Laboratory Services (Chemistry, Hematology, Microbiology, Blood Banking, Urinalysis); (e) Use of Microbiology Package, and (f) Use of Blood Banking Package.
  - Radiology to include (a) Plain Films, (b) Fluoroscopy, (c) Mammography, (d) Ultrasound, (e) Documentation of Radiology Exams performed on date other than date ordered; (f) Radiology Reports (how the radiology reports are received and entered into the RPMS Radiology Package).

- Pharmacy to include (a) Immunizations; (b) Injections; (c) Outside Prescriptions; (d) Over-the-Counter Medications; (e) Documentation of Patient Education; (f) Paperless Refill Process; (g) Documentation of Medications Picked Up and Medication Counseling when patient or proxy picks up medications on a date other than processed; (i) Emergency Room Medications; (j) Phone Refills; (k) Verbal and Telephone Orders.
- Ancillary Services to include (a) Physical Therapy; (b) Nutrition; (c) Diabetes Education; (d) Specialty Clinics.
- Medical Records to include (a) Documentation Review; (b) Use of Pink and Yellow Copies of PCC Forms; (c) Use of PCC+ and Copies; (d) Delinquency.
- PCC Data Entry Process (Data Entry will Utilize the PCC Form that was Utilized During the Walk-through) to Include (a) Data Entry Mnemonics; (b) ICD-9 Coding; (c) E-Codes; (d) CPT Coding; (e) E&M Codes, (f) Utilization of PCC Form when Data Entry is Complete; (f) Error Reports; (g) Orphan Lab, Pharmacy, Radiology, and Immunization Reports; (h) Uncoded Diagnoses Reports; (i) Use of Super Bill; and (j) Allergies vs. Adverse Tracking.
- Review Data Entries Utilization of Mnemonics for (a) tobacco use; (b) CAGE; (c) Interpersonal Violence; (d) Elder Care; (e) Public Health Nursing; (f) Barriers to Learning; (g) Learning Preference; (h) Patient Education; (i) Refusals; (j) Historical Information; (k) Diabetes Foot Exam; (l) Diabetes Eye Exam; (m) PAP Smears; (n) Mammograms; (o) Immunizations; (p) Historical Immunizations.
- Third Party Billing Process to include (a) Utilization of PCC Form; (b) Utilization of Superbills; (c) ICD-9, CPT, E&M Coding; (d) Billing Reports; (e) Denials; (f) Accounts Receivable.

Day Two

Time: 8:30 A.M. - 12:00 P.M.
1:00 P.M. - 5:00 P.M.

At the end of this session EHR Implementation Team Members will have completed:

- Basic EHR Set-Up
- Patient Context Configuration
- Encounter Context Configuration
- Setting Up a New User
- TIU Configuration
  - Setting Up Basic Document Parameters
  - Creating Note Titles
  - Business Rules
  - Minutes Regarding Discussion of Printing Notes
- Review PCC Master Index Control, all package links activated
- Notifications Configuration
- Order Entry Configuration
  - OE/RR Security Keys
  - Order Checks
  - Order Parameters
  - Print Report Parameters
- Remaining Master EHR Parameter Configuration
- Consult Tracking Configuration

Documents needed include (a) List of all employees to include their registration, license, certification; (b) Provider DEA Numbers (If Provider does not have a DEA Number will need the facility DEA Number (needs to be entered in Institution File) and last four digits of the provider's social security number; (c) Examples of PCC and/or PCC+ forms and/or a list of their Titles; (d) Minutes of EHR Teams Discussions re: Notifications and Order Checks; (e) Physicians' Paper Draft of Order Menus; (f) Standing Orders for Order Sets; (g) EHR Teams Minutes re: discussions of printing orders; (h) a list of all "In-House" consultations and/or referrals and a list of all persons and/or teams that will receive the consult.

Day Three

Time: 8:30 A.M. - 12:00 P.M.
1:00 P.M. - 5:00 P.M.

At the end of this session EHR Implementation Team Members will have completed:

- Review TIU Templates
- Review Picklists and Superbills
- Vuecentric Template
- Review Walk-Through Recommendations
- EHR Team and Consultants Develop EHR Implementation Plan and Closeout

Documents needed include (a) examples of all “Super Bills,” “Charge Tickets,” and “PCC+ Forms”; and (b) RPMS-PCC “Frequency of Procedures” and “Frequency of Diagnosis” Report.

EHR Outpatient Setup

Tentative Schedule – This could include a Day 4 session

Day 1	Day2	Day 3
9:00 AM - 11:00 AM Introductions and EHR Team Presentations of Site Tracking Record Progress **11:00 AM - 12:00 PM** Begin Walk-Through • Demo Patient Check-In	**9:00 AM - 12:00 PM** Basic EHR Setup • TIU User Classes • Security Keys OE/RR • Note Titles • Business Rules • TIU Parameters	**9:00 AM - 12:00 PM** Continue EHR Setup • Review Templates • Review Picklists and Superbills • Vuecentric Template
12:00 PM - 1:00 PM LUNCH	**12:00 PM - 1:00 PM LUNCH**	**12:00 PM - 1:00 PM LUNCH**
1:00 PM - 5:00 PM Continue Walk-Through • Demo Patient Screening • Medical Visit • Laboratory Services • Radiology Services • Pharmacy Services • Identify Ancillary Services - PT, Diabetes, Specialty Clinics, CHS • Medical Records & Data Entry • Third Party Billing - Patient Business	**1:00 PM - 5:00 PM** • Review PCC Master Index Control, all package links activated • Notifications Configuration • Order Check Configuration • Remaining Master EHR Parameter Configuration • Identify In-house Consult Services, teams, and network printer names	**1:00 PM - 2:00 PM** • Conclude Residual Setup Tasks **2:00 PM - 5:00 PM** • Review Walk-Through Recommendations • EHR Team and Consultants Develop EHR Implementation Plan and Closeout